SECTION FOUR CONTINUUMS

I. CONTINUUM OF CARE CORE REQUIREMENTS

A. Continuum Model

1. Overview

The Continuum model was developed in order to effectuate changes in the way out-of-home services were delivered to children in the custody of the state. The goals of the continuum model were to allow providers greater flexibility in designing services for children and families, the ability to facilitate rapid movement of children through the service system toward permanency and the ability to customize the delivery of services to children and families in the least restrictive, family-like setting appropriate to needs and strengths in the most cost-effective manner.

The Continuum of Care is a service-based model that purchases the outcomes of successful permanency for children and provides incentives for placement in the most appropriate, least restrictive, community-based settings. In addition to residential treatment or group home settings, continuum care provides a broad array of treatment and case management services ranging from residential to community-based services. These services are delivered by providers in such a way as to meet the clinical, behavioral and medical treatment needs of children.

Children enter a continuum program at a specified level of care. Currently there are three continuum levels of care - Level 2 Continuum, Level 3 Continuum and Level 3 Continuum Special Needs (L3 CSN). Continuum services are initially provided to children in DCS custody in a variety of settings but may continue after a child returns home for a period of time to be determined by the recommendations of the most recent Child & Family Team Meeting (CFTM).

2. Continuum Requirements

The continuum model requires providers to have the full array of services that will appropriately meet the needs of children at the assigned level. The continuum reimbursement rate is set at a level that is targeted to encourage providers to move children to permanency or least-restrictive settings quickly and appropriately. This includes in-home services.

a. Level 3 Continuum Special Needs (L3CSN)

Providers awarded a L3 CSN contract will be required to serve children in need of both L3 Continuum and L3 CSN services under the L3 CSN contract. The L3 CSN provider will be responsible for delivering all services necessary for maintaining the stability of the child. If an agency is unable to provide a particular service to a child directly, the provider must procure the service from an appropriately credentialed entity. Children cannot be disrupted from this level of care based on an unavailability of services. In addition, children cannot be disrupted from this program based upon an admission to the psychiatric hospital. A child must be re-staffed following return to the L3 CSN program if the provider determines that the needs of the child have changed significantly.

1. The categories of L3CSN services that will be available are: Alcohol & Drugs (A&D), Sex Offender (SO) and mental health/behavioral (MHB). Providers may provide any or the entire specialty service range (A&D, SO, MHB). Providers delivering MHB services must do so statewide and must maintain a positive Chapin Hall comparative score of 0-8.

a. L3 CSN providers must have access to a Residential Treatment Facility (RTF) either through direct operation of a RTF or through a sub-contracting agreement. The RTF must maintain a Department of Mental Health and Development Disabilities (DMHDD) license (Mental Health Residential Treatment Program) and meet additional clinical standards developed by DCS as detailed in the Provider Policy Manual (PPM);
b. DCS will assess each RTF to determine whether these facilities meet the enhanced clinical services beyond what is required by the DMHDD license;

2. A L3 CSN provider delivering MHB services must have the clinical capacity and ability to serve children statewide, with clinical needs that meet or exceed the standard Level 3 Continuum but do not rise to the Level 4 criteria of sub-acute care. In addition to a higher clinical need, other descriptors of children in need of L3CSN services will include, but are not limited to: conduct disorder, oppositional defiant, aggressive, low-functioning, delinquent adjudications, gang affiliation, etc. Though the agency can make the determination as to the most appropriate setting at time of referral, the agency will be fully responsible for securing placement at an RTF if the behaviors of the child warrant such a placement;
3. Children referred for L3 CSN will have more difficult and challenging needs/behaviors and will most likely have an immediate need for short-term stays in an RTF with higher-defined clinical components;
4. Level 4 children that are stabilized and ready for step-down must be accepted, upon referral, to the L3 CSN level of care. Assessment of these youth must identify them as appropriate for L3 CSN;
5. L3 CSN providers must maintain an ongoing capacity of 40-45% RTF and group home capacity. This number is in compliance with the PPM's requirement of at least 50% placements in non-restrictive settings. Of the 40-45% capacity, 70-75% must be RTF capacity. Capacity will be monitored on an ongoing basis and tracked through TFACTS by CPPP. Provider's contracts will reflect the capacity requirements beginning July 01, 2010;
6. All L3 CSN providers must maintain, or have access to, the full array of services to meet children's needs at this level, including the RTF setting. The following services must be available to the provider either directly or through a sub-contractual arrangement:
   a. Independent Living Services;
   b. Foster Care;
   c. Continuum Foster Care;
   d. Medically Fragile Foster Care;
   e. Level 2 care (Mental Retardation, Education, Community Alcohol & Drug, Community Sex Offender);
   f. Level 2 Group Care;
   g. Level 3 Continuum care (Mental Retardation, Education, Alcohol & Drug, Sex Offender);
   h. Residential Treatment Facility (RTF) with additional clinical requirements defined in the DCS Scope of Services;
   i. In-Home services; and.
   j. Adoption services (must have specialized adoption staff identified for delivering this service component).

7. In accordance with their Level 3 contractual agreement, providers are required to accept all referrals for children deemed to meet the need for this level of service unless the provider is at full capacity or if the provider has justified clinical documentation that indicates either a higher level of care or a Youth Development Center (YDC) placement is more appropriate. Such a scenario will require either the region or the provider to file an appeal under the CFTM appeals process;
8. Once a child is accepted into a provider's L3 CSN, the provider will be held responsible for the care and treatment of the child through their exit from custody to permanency. There are only four (4) justifiable reasons for the disruption of a child from a L3 CSN:
    a. The child's needs have increased beyond the current L3 CSN scope of services;
    b. The child has incurred additional serious juvenile justice charges that significantly increases the community risk and the child is most appropriate for a YDC setting (see the appeal section above);
    c. The step-down (from a higher to a lower contract) of a child can be considered only if the child has maintained in a resource home consistently with no RTF placements for a period of eighteen (18) months or more. One exception to the eighteen (18) month rule is if the child is in a pre-adoptive placement. The CANS and CFTM must agree to the recommendation for the move to a lower level of care. The provider has the right to appeal the decision in accordance with the CFTM appeals protocol; and
    d. The disruption of a pre-adoptive placement which necessitates an immediate alternative pre-adoptive placement that is in the best interest of the child. This decision should occur in conjunction with the child's team where the team may have identified a possible alternative placement outside of the current provider's network of services that more effectively meets the child's needs
9. Children are not disrupted from this program based upon an admission to a psychiatric hospital. A child must be re-staffed following return to the L3 CSN program if the provider determines that the needs of the child have changed significantly;
10. A L3 CSN child will remain at this level of service regardless of the placement setting and the child's stabilization. Based on this model, the Department cannot reduce a child's level of service arbitrarily, unless as defined above. This extends to the in-home services component; and,
11. Providers issued a L3 CSN contract will continue to receive Level 3 Continuum children that will be served under this contract.

b. Level 3 Continuum:

The Level 3 Continuum provider will be responsible for delivering all services necessary for maintaining the stability of the child under a Level 3 Continuum contract. If an agency is unable to provide a particular service to a child directly, the provider must procure the service from an appropriately credentialed entity. Children cannot be disrupted from this level of care based on an unavailability of services.

1. Level 3 Continuum providers must have access to a Residential Treatment Facility (RTF) either through direct operation of a RTF or through a sub-contracting agreement. The RTF must maintain a DMHDD license as detailed in the Provider Policy Manual (PPM);

2. The Level 3 Continuum providers will be expected to maintain an ongoing minimal capacity of 10 - 15% RTF and group home capacity. The calculation of the capacity will be based on the total number of L3 Continuum children/youth served annually. Capacity will be monitored on an ongoing basis and tracked through TFACTS by CPPP. Provider's contracts will reflect the capacity requirements;
3. All Level 3 Continuum providers must maintain, or have access to, the full array of services to meet children's needs at this level of service, including an RTF. The following services must be available to the provider either directly or through a sub-contract arrangement:
   a. Independent Living Services;
   b. Foster Care;
   c. Continuum Foster Care;
   d. Medically Fragile Foster Care;
   e. Level 2 care (Mental Retardation, Education, Community Alcohol & Drug, Community Sex Offender);
   f. Level 2 Group Care;
   g. Level 3 care (Mental Retardation, Education, Alcohol & Drug, Sex Offender);
   h. Residential Treatment Facility (RTF) with additional clinical requirements defined in the DCS Scope of Services;
   i. In-Home services; and.
   j. Adoption services (must have specialized adoption staff identified for delivering this service component).
4. In accordance with their Level 3 Continuum contractual agreement, providers are required to accept all referrals for children deemed to meet the need for Level 3 Continuum services unless the provider is at full capacity;
5. Once a child is accepted into a provider's Level 3 Continuum, the provider will be held responsible for the care and treatment of the child through their exit from custody to permanency. There are only three (3) justifiable reasons for the disruption of a child from a Level 3 Continuum:
   a. The child's needs have increased beyond the current Level 3 Continuum scope of services;
   b. The child has incurred additional serious juvenile justice charges that significantly increases the community risk and the child is most appropriate for a YDCS setting (see the appeals section above), and,
   c. The step-down (from a higher to a lower contract) of a child can be considered only if the child has maintained in a resource home consistently with no RTF/group home placements for a period of eighteen (18) months or more. One exception to the eighteen (18) month rule is if the child is in a pre-adoptive placement. The CANS and CFTM must agree to the recommendation for the move to a lower level of care. The provider has the right to appeal the decision in accordance with the CFTM appeals protocol.
6. Children are not disrupted from this program based upon an admission to a psychiatric hospital. A child must be re-staffed following return to the Level 3 Continuum program if the provider determines that the needs of the child have changed significantly;

7. A Level 3 Continuum child will remain at this level of service regardless of the placement setting and the child's stabilization. Based on this model, the Department cannot reduce a child's level of service arbitrarily, except as defined above. This extends to the in-home services component; and,
8. The Level 3 Continuum provider will be responsible for delivering all services necessary for maintaining the stability of the child. If an agency is unable to provide a particular service to a child directly the provider must procure the service from an appropriately credentialed entity. Children cannot be disrupted from this level of care based on an unavailability of services.

c. Level 2 Continuum:

The Level 2 Continuum provider will be responsible for delivering all services necessary for maintaining the stability of the child under a Level 2 Continuum contract. If an agency is unable to provide a particular service to a child directly, the provider must procure the service from an appropriately credentialed entity. Children cannot be disrupted from this level of care based on an unavailability of services.

1. Level 2 Continuum provider or sub-contractor will maintain a DCS license and meet the clinical requirements defined in the PPM;
2. All Level 2 Continuum providers must maintain or have access to the full array of services. The following services must be available to the provider either directly or through a sub-contracting arrangement:
   a. Independent Living Services;
   b. Foster Care;
   c. Continuum Foster Care;
   d. Medically Fragile Foster Care;
   e. Level 2 care (Mental Retardation, Education, Community Alcohol & Drug, Community Sex Offender);
   f. Level 2 Group Care;
   g. In-home services; and,
   h. Adoption services (must have specialized adoption staff identified for delivering this service component).
3. In accordance with their Level 2 Continuum contractual agreement, providers are required to accept all referrals for children deemed to meet the need for Level 2 Continuum services unless the provider is at full capacity;
4. Once a child is accepted into a provider's Level 2 Continuum, the provider will be held responsible for the care and treatment of the child through their exit from custody to permanency. There are only three (3) justifiable reasons for the disruption of a child from a Level 2 Continuum:
   a. The child's needs have increased beyond the current Level 2 Continuum scope of services;
   b. The child has incurred additional serious juvenile justice charges that significantly increases the community risk and the child is most appropriate for a YDC setting (seethe appeals section above), and;

c. The step-down (from a higher to a lower contract) of a child can be considered only if the child has maintained in a resource home consistently with no group home placements for a period of eighteen (18) months or more. The exception to the eighteen (18) month rule is if the child is in a pre-adoptive placement. The CANS and CFTM must agree to the lower level of care recommendation. The provider has the right to appeal the decision in accordance with the CFTM appeals rule.

5. Children are not disrupted from this program based upon an admission to a psychiatric hospital. A child must be re-staffed following return to the Level 2 Continuum program if the provider determines that the needs of the child have changed significantly;
6. A Level 2 Continuum child will remain at this level of service regardless of the placement setting and the child's stabilization. Based on this model, the Department cannot reduce a child's level of service arbitrarily, except as defined above. This extends to the in-home component; and,
7. The Level 2 Continuum provider will be responsible for delivering all services necessary for maintaining the stability of the child. If an agency is unable to provide a particular service to a child directly the provider must procure the service from an appropriately credentialed entity. Children cannot be disrupted from this level of care based on unavailability of services.

B. General Characteristics

The continuum of care is a service model with a focus on achieving the outcome of successful permanency for children in a family setting. Continuums have the flexibility to design individualized services for children and families, in coordination with a Child and Family Team, and the ability to customize the delivery of services to each child and family in the most appropriate manner. A continuum is an array of services for children with moderate to severe mental health and behavioral issues and their families, including:

1. residential treatment (Level 3 RTF) and group care services,
2. resource homes with wraparound services,
3. in-home services,
4. adoption services,
5. independent living services, and
6. support and services to the child's family.

The goal of all continuum services is timely permanency and well being for the children served.

C. Admissions /Clinical Services and Movement in a Continuum

Continuums must have the capacity for immediate admission of children into the program, including children who are just entering custody and for whom there is limited presenting information but initial review indicates the child's needs meet the scopes of services. Continuum providers will assist in initial assessment, planning, and service development for all children and families, within the timelines required by the Department of Children's Services.

1. Admission

   At admission, initial placement is made in the most appropriate placement, given assessments, referral information, community safety, clinical services, family liability/safety, and educational needs. Any child who is admitted to the contract is treated as a full admission. Each youth and family must have access to the full range of services as identified in the CFTM and follow policies related to the provider contract.

2. Movement

   Stability in placement is a priority for all children and families. Movement of a child should be minimal, if at all. Any movement of a child must be in coordination with a CFTM held with all involved adults and age appropriate child. The movement should also be determined to facilitate timely permanency and in the best interest of the child and family. Should a move be necessary due to an emergency situation, the DCS FSW must be informed and give permission prior to the move. If after hours, notification and permission must be obtained the next business day. A CFTM must be held within three (3) business days in these situations. A Notice of Action is required for any disruption, termination, or discontinuation of services. The agency, in coordination with the child and family team, must have services available that are targeted to reduce instances of disruption or moves for all children. These services should be designed specifically for children identified by presenting information or evaluations, as being at risk for disruption or move.

3. Respite

   Respite is defined as a brief period of relief from care giving, usually seventy-two (72) hours or less, with the child returning to the original placement. Any other change of placement is considered a move and reported and reviewed by a CFTM as a move.

4. Transition

   In some cases, a client may be eligible for a more appropriate level of care currently provided by the continuum (for example, the client is Level III and now meets criteria for Level II). This decision is to be made in the context of the CFTM, and there must be clear documentation and reasoning to decrease the intensity of services to the client. If the provider does not agree that a client should be transitioned, the appeals guidelines outlined in SECTION ONE, Chapter III, W of this manual should be used.

D. Personnel (Residential)

1. Adequate care and supervision is provided at all times to assure that children are safe and that their needs are met, in accord with their developmental level, age, and emotional or behavioral problems, and include
   a. at least one on-duty child care worker providing continuous supervision for each living group of eight children or youth;
   b. higher adult/child ratios during periods of greater activity;
   c. availability of additional or back-up child care personnel for emergency situations or to meet special needs presented by the children in care; and
   d. overnight awake staff at 1:8 ratio.
2. No more than five (5) experienced providers of case coordination or casework service report to one (1) supervisor.

3. The case loads for personnel providing therapeutic support and case coordination services do not exceed fifteen (15) residents, and may be adjusted according to current case responsibilities.
4. The agency has the services of a licensed physician available on at least an on-call basis to provide and/or supervise medical care.

E. Resource Parent Training

The agency will meet all criteria as outlined in Core Standards for Foster Care.

F. Individualized Treatment Plans

The agency will meet all criteria as outlined in Core Standards.

G. Service Overview

The primary focus and goal of the continuum is the development and implementation of participate in decisions and assessments regarding safety, placement, permanency, family strengths, and underlying needs. CFTMs are convened at all critical decision-making junctures and are used in development and implementation of treatment planning. Individualized treatment plans outline coordination of the services and resources with the needs and strengths of the family, specifying the desired outcomes and projected time frames.

H. Education

1. Children in foster care typically attend public school.
2. Students in residential programs licensed as **Family Boarding Homes** or **Maternity Homes** typically attend public school.3.
   Students in residential programs licensed as **Group Care Homes, Child Placing Agencies, and Residential Child Care Agencies** may attend public school. Regions and providers must work collaboratively through the CFTM process to determine placement options for a child/youth with zero tolerance needs. The DCS Education Specialist MUST be included in the CFTM.
4. Students in residential programs licensed as **Residential Treatment Facilities, Mental Health Hospital Facilities, Residential Rehabilitation Treatment Facilities or Mental Retardation Residential Habilitation Facilities** must have an approved in-house school site available for students.

   (For additional licensure information, see Section 9, Attachment 8, titled *Licensure Matrix.)*
5. Providers should meet all criteria outlined in Section 9, Attachment 9, *titled Educational Standards for DCS Providers.*

I. Service to the Child/Youth Refer to Services for All Children in Custody in Core Standards

In-Home Services – See Section Seven for specific details.

1. Providers of continuum services have the flexibility to deliver the level of services needed by the child and family in the most appropriate setting.
2. Ideally, the services may be provided in the child's home, or identified permanency person's home, with the support and services necessary, at the intensity level required for the child and family to be successfully reunified.

J. Documentation/Utilization Review

1. The provider, in conjunction with a Child and Family Team Meeting, shall review the treatment plan.

2. Monthly summaries shall be completed for each child enrolled in the continuum program. Providers should use the DCS Provider Monthly Summary Outline as a guide for providing information. This guide is available on the Provider Page of the DCS web site.

   Monthly summaries are used to document the services provided by the agency to the child, including services provided directly by the agency, or services coordinated for the child. Health services provided or coordinated by the agency are included in the child welfare tracking system, and build a health summary for the child which provides information about the health history to providers serving the child. The summaries shall be provided each month to each of the following persons:

   a. the Involved Adult for the child (biological, adoptive, or resource, as applicable),
   b. the DCS Well-being Regional SAT Coordinator and
   c. the TennCare Consumer Advocates

   The DCS Well-being Regional SAT Coordinator enters the health information from the monthly summary into the child welfare tracking and provides the monthly summary to the assigned FSW. The TennCare Consumer Advocates review services for determination of the TennCare appeal concerns. The address of the TennCare Consumer Advocate is P.O. Box 281858, Nashville, TN 37288

3. The Continuum program shall provide to the child's Involved Adult (biological, adoptive, or resource family, as applicable), at least monthly, a copy of any Serious Incident Reports submitted to DCS. This copy is provided in addition to any outreach by telephone to inform the Involved Adult of the status of the child being served by the Continuum program. Also note that, in addition, the Tenncare Consumer Advocates receive, electronically, IRs filed on behalf of custodial children in continuum contract provider agencies.
4. Monthly summaries are reflective of the daily treatment notes, home visits, family and children visits and contact, coordinated meetings with departmental staff, court hearing, foster care review hearings, school liaison services, medical services, dates of parent and sibling visitation, and outline progress and barriers toward all identified treatment needs of the child and family.
5. A continuum provider shall provide notice to DCS, an Involved Adult (if any), and the Advocacy Contractor of the monthly summary and serious incident reports as required by DCS policy. The notice required by this section shall include a copy of the treatment report and, in the case of the Involved Adult, shall be accompanied by information regarding the availability of the TennCare appeals process and how to invoke that process on the child's behalf.
6. There must be a treatment plan review and update at least quarterly, or when indicated as needed by the child, family, or as a result of a child and family team meeting.
7. The frequency and intensity of interventions may vary as the needs of a child and family change or as priorities are established through the CFTM.
8. A CFTM is required, with notice to all involved adults and the child, if age twelve or above, prior to reduction, change, or termination of services.
9. For each child admitted into the continuum, the CFTM shall have identified specific milestones for the child and family as progress is made toward permanency. Movement to a lower or higher intensity of care must be fully documented through a CFTM and includes the required TennCare Notice of Action completed by the DCS FSW and mailed to the attendees of the CFTM.

10. Documentation, frequency and intensity of services must follow the requirements outlined in the Provider Policy Manual for the level of service and placement type.

11. Clinical Review There must be a clinical review, with all involved adults, clinical services providers, and the child in any situation when a child remains in residential treatment or group care in excess of six (6) months, continuing monthly or as determined by the CFT, until a less restrictive service is identified and/or developed. This review is part of a CFTM and includes the person(s) providing clinical services and the regional psychologist. The team will evaluate the ongoing need for residential services; develop a plan that facilitates discharge to less restrictive setting, recruitment of family support, or other services as appropriate to meet the child's clinical needs. The continuum provider requests that the Child and Family Team be convened and developed in these circumstances.

12. Performance Measures

    a. At least annually, the Department of Children's Services will review the agency's performance. Contract expansion, contract reduction, corrective action plans, admission and referral rate, and/or termination will be determined based on agency's performance as compared to same contract types and the agency's past performance in these areas.

    b. All children admitted to the contract and discharged from the continuum will become part of the provider's outcome evaluation and aftercare program. Discharge occurs when the child and family are no longer receiving reimbursable continuum services and as a result of a CFTM with all involved adults and age-appropriate child.

K. Discharge Criteria

1. Successful Discharge Discharge from the continuum to a permanency placement identified in the permanency plan is a successful discharge.

    a. Discharge planning is a result of a CFTM and Notice of Action completion.

    b. The CFT may determine that a child should be discharged from the continuum contract, moving to a regular foster care contract with a negotiated relative planned permanency living arrangement, independent living with support family, or to adult services provided through the Department of Mental Health/Developmental Disabilities and has successfully achieved permanency, completing continuum services and such transition best meets the needs of the child and family.

2. Unsuccessful Discharge Unsuccessful discharge is exit from the contract to a higher level of care, another agency of the same level of care, homelessness, and runaway without readmission, and detention or jail without return to the program.

    a. The continuum of care services model is designed to implement a variety of services based on the varying needs of children and families. It is expected that discharge of a child, prior to completion of the program, will not be requested. The provider shall not request the removal of a child from the program for such reasons as noncompliance with house rules, reported lack of "motivation," or lack of progress in the program.

b. The provider may request in writing a CFTM to remove a child from the continuum program if the child has validated, diagnosed, or adjudicated behaviors, which would place him/her in the category of children who are not eligible for admission to the program. The provider shall be expected to exhaust all available means of service intervention prior to requesting such discharges.
c. De-authorization should be a consensus decision among the provider, all involved adults, family, age-appropriate children, and the DCS FSW. De-authorization follows a Child and Family Team Meeting.

d. The provider shall adhere to all state-approved guidelines for CFTM and discharge planning prior to any child's removal from the program. A Notice of Action is required for any determination, reduction, or suspension of services to all involved adults.
e. The provider shall be responsible for the provision of appropriate services to children placed in detention. In such cases, the child and family shall be provided with a revised treatment plan and the child shall be returned to an appropriate level within the continuum following release from detention.

II. LEVEL II CONTINUUM

A. Admission/Clinical Criteria

1. Children eligible for this level program have been identified by a mental health professional as having at least moderate emotional/behavioral/medical problems and are in need of treatment.
2. Children may also have the following behavioral characteristics and/or treatment needs:
   a. Substance abuse treatment needs which require intervention and targeted services but do not indicate a need for acute services or detoxification;
   b. Children may be adjudicated delinquent, unruly, or dependent/neglect and there may be specific court imposed expectations for program intervention;
   c. Children may have a history of chronic runaway, manipulative behaviors, have difficulty maintaining self-control, display poor self-esteem, have difficulty in securing and maintaining close relationships with others, be habitually truant from school, have difficulty in accepting authority, and may have delinquent charges or court involvement history. Some children may be in need of psychotropic medication and follow up. At this level, children typically have need of behavioral and treatment intervention to be able to function in school, home, or the community because of multiple problems. Children requiring Level II services may have a need for constant adult supervision and will need behavioral intervention and therapeutic support;
   d. Children may have treatment needs due to sexual, physical, and or emotional abuse or neglect, which require specialized therapies and coordination of interventions and services. This is in addition to the services provided through therapeutic support. Such specialized counseling/therapy is provided by a licensed and properly credentialed practitioner and coordinated through the provider.
3. Families of these children often have need for intervention, therapeutic support, and coordination of services and may have multiple needs including need for coordination of counseling/therapy, alcohol and drug intervention, community support, mental health service coordination, domestic violence intervention, or other issues.
4. Children with a history of sexual offenses are eligible if they have successfully completed a sex offender treatment program and/or have been deemed not to pose a serious risk to the community as recommended by a recognized sex offender treatment professional.
5. These children have not successfully responded to less intensive interventions or have been denied admission or discharged from less intensive placements because of their emotional or behavioral problems.
6. A diagnosis of mental retardation may not be used as the sole basis to refuse admission to a child when the child's behavioral issues fall within the program's Scope of Service. Review of referrals of children with a diagnosis of mental retardation must be based on assessment of both the child's intellectual and adaptive level of functioning, using professionally accepted assessment instruments.
7. The agency may not deny admission to children who have been determined to meet the scope of services, provided the child is being placed according to his/her specific needs.
8. Children who are considered ineligible for Level II programs are those who are severely autistic, actively psychotic, diagnosed with moderate or more severe mental retardation, unless the program is designed to serve children with mental retardation, or who are actively suicidal or homicidal. Other

youth who are ineligible for this level treatment program are those who have displayed major acts of violence or aggression which indicate a risk to the community, such as rape, unless the program is designed to serve sex offenders, arson, assault with a deadly weapon, murder, or attempted murder within the past six (6) months.

B. Personnel

1. The service has qualified personnel who can meet the developmental and therapeutic needs of all children accepted for care and services.
2. The agency shall adhere to the personnel requirements for each placement type within the continuum, as outlined in the Core Standards, Foster Care, Continuum Foster Care, and Residential sections of this manual.

C. Service Overview

1. The agency shall meet the standards set forth in Section One, Core Standards; Foster Care; Continuum Foster Care; and Residential.

   At least 75% of children in a Level II Continuum must be in a family-based setting.
2. Each youth and family must have access to the full range of services as identified in the Child and Family Team meeting and follow policies related to this contract
3. Level II continuums develop and provide services in a flexible, individualized manner to best meet the needs of the child and family. Service needs are determined through the utilization of Child and Family Team meetings. Services are determined through a review of expected discharge placement as indicated in the child's Permanency Plan, referral information, history, and treatment needs of the child and family.
4. All services provided are to be culturally and linguistically competent, recognizing the cultural, language, and ethnic heritage of the children and families being served. Services must be provided in the context that respects and best meets the unique cultural and ethnic needs of a child and family.

D. Service Components Provided within the per diem

The following services are required **within the per diem** payment:

1. **Therapeutic support.** Non-medically necessary intervention and support services in the form of individual, group, or family interaction, which address behavioral or mental health needs to improve social, educational, or psychological functioning.
   a. **Sexual Abuse and Sexual Perpetration Intervention**. Behavioral intervention and support services to address issues related to sexual abuse and/or sexually reactive behaviors in coordination with outpatient therapy recommendations and the needs of the child and/or family.
   b. **Substance Abuse Intervention**. Behavioral intervention and support services targeting issues related to alcohol and/or drug misuse in coordination with outpatient therapy recommendations and needs of the child and/or family.
2. **Coordination of Counseling/Therapy Services**. Referral and **coordination** of medically necessary outpatient counseling/therapy services as indicated in the child's Permanency Plan and/or prescribed to meet the mental health needs of the child.

3. **Case Management**. Case management/coordination services are provided by an individual, who at a minimum has a bachelor's degree in one of the social sciences and at least one year of social services experience. Case management includes coordination with the Child and Family Team in the development and implementation of the treatment plan, monitoring the implementation of this plan, and locating all services and placements a child and/or family may need while enrolled in the continuum. Case Management includes participating in all Child and Family Team Meetings, attending all foster care review meetings, and court hearings. It also includes documenting progress, barriers and resolution to these barriers, maintaining contacts with the DCS FSW, revising the treatment plan as needed, maintaining ongoing contacts with the child and/or family, planning and implementing the progression of the child and/or family through the continuum. Child and Family Meetings will be utilized at all critical decision making points.
4. **Family Services**. Services provided to family members and persons identified in the Permanency Plan or Child and Family Team Meeting or who are identified as discharge options, which facilitate reunification, kinship care, permanency, or adoption. Services to families include linking families to community resources and services to increase stability and meet the goals of the permanency plan. Services to the family begin at the admission of the child into the contract and are fully incorporated into all treatment plans. Flexible funding may be requested through the DCS FSW to address the basic living needs of the family (rent, utilities, child care, etc.), or identified service needs that are not covered in the Scope of Services.
5. **Diligent Search**. This service is a search for potential family members to be a support or placement for a child and/or recruitment of family or individual to be an adoptive, resource, relative, or planned permanency living arrangement support for a child.
6. **Independent Living Services**. These services include therapeutic support, skill building, service coordination, and life skills coaching/support that focus on facilitating the skills and support for the child to live successfully and independently in the community. Age appropriate self-sufficiency skills must be incorporated into treatment plans for all children. Children ages fourteen (14) and above must have specific independent living skills training and development incorporated into service and treatment plans. Establishing connections with persons able to provide support throughout the child's life is an essential component of this service and to successful independence. Chaffee Independent Living Funding may be used to augment services as outlined in Independent Living Policy.
    a. **Job Placement Assistance**. Assistance provided by the Provider, contracted staff, certified guidance counselor, school system, or other approved entity, in helping a child find appropriate part or full-time employment.
    b. **Vocational Assessments/Services/Planning/Training**. Administering and implementing vocational aptitude assessments, interest surveys, vocational planning and coaching, and vocational training. Services for vocational training and coaching may be accomplished through enrollment in vocational training courses or approved apprenticeships.
    c. **Self Sufficiency Skill Training**. Evaluation of the level of independent living skills, with targeted training, mentoring, coaching, and teaching of skills to enable independence as part of the treatment plan and delivery
    d. **Development of Planned Permanency Living Arrangement Contract**. Development and signature of P.P.L.A. contract for youth, specifying relatives or adult(s) committing to ongoing support, as appropriate for the child.

e. **Transitional Living Services**. Career planning, enrollment preparation for post secondary education, apartment living, or other appropriate services for children moving to independence

7. **Adoption Services**. Continuums are required to provide the full range of adoption services to all children in DCS full guardianship in the care of the Continuum whose goal is adoption. The Continuum Provider will provide full case management services for foster care and for adoption, if appropriate; perform all steps necessary to prepare the child for adoption; perform all steps necessary to provide diligent search for an adoptive family and prepare the adoptive family; perform all services necessary to place the child for adoption, including compliance with legal requirements and other binding documents, ICPC, and securing adoption assistance when the child is eligible; perform post placement services through finalization of the adoption; provide post finalization services; respond to disruptions; and complete all required reports and procedures, including sealing of the adoption record. Continuum Providers will be reimbursed at the per diem rate for the adoption services delivered up to the date of the signing of the adoption placement agreement with an adopting family. *See Section Eight -ADOPTION*

8. **Adjunct and Specialized Services**. The needs of each child and family are unique. All services must be individualized, based on the needs of the child and family and barriers identified by the CFT.

- Services may be obtained by utilizing community resources, developed by the Agency, or obtained through a subcontract arrangement.
- Services identified by the CFT as necessary for the child and family that are not covered in the Scope of Services may be accessed or developed through a flex funding request made by the DCS FSW. Appropriately licensed/certified and supervised professionals must provide out patient, medically necessary counseling/therapy and medical services to include:

a. **Parenting Skills Training.** Individualized coaching and training to assist parents with issues related to discipline, child development, child-rearing skills, and behavioral intervention. Services must meet the needs of the family as identified in the Permanency Plan and be available at times, locations, which best meet the family's needs.

b. **Dietetic and Nutrition Services**. Services that are necessary to address issues related to diabetes control, obesity, malnutrition, and/or eating disorders.

c. **Coordination of Medical and Nursing Services**. Coordination and documentation of all Early Periodic Screening Diagnosis and Treatment (EPSDT) services provided by a licensed health care provider of the type and duration indicated by documented medical need.

d. **Crisis Intervention/Stabilization**. Services provided on a twenty-four (24) hour basis to a child and/or family experiencing a medical, mental health, parent/child interaction, or other significant emergency need. Services must, at a minimum, be provided by an individual with a bachelor's degree in one of the social sciences with one-year experience and who has supervisory access to licensed professional possessing, at a minimum, a Master's Degree in one of the behavioral sciences.

e. **Emergency Placement Services**. Services will be available 24 hours a day through an on-call system that stabilizes children and families by locating alternative short-term placement in emergency situations.

f. **Respite**. Services to provide agency resource parents or family members appropriate periods of break in care giving. Respite is defined as a brief break in care, with the child returning to the original placement. Respite is generally seventy-two (72) hours or less in duration.

g. **Community Support Services**. Services include identification, recruitment, development, and referral to community services to support the service needs of the child and/or family to maintain and facilitate permanency. Coordination with community support is an essential component of services to children and families.

h. **Services for Developmentally Delayed Children**. Specialized services designed to address the developmental deficits and developmental skills needed and assistance with transitioning youth to adult services in coordination with the Department of Mental Health and Developmental Disabilities (DMRS).

i. **Family Planning Counseling and Referral**. Education and guidance provided to a child and/or family regarding planning/preventing pregnancy. These services may include alternatives available for pregnant teens.

j. **Placement Stability and Intervention**. These services include wraparound, emergency response, crisis intervention, or child/family specific intervention and support which stabilize placement and avoid movement or disruption. Services are available 24 hours on an on-call basis.

E. Services to the Family

When a child is in an out-of-home placement but the Permanency Plan has identified reunification with family as a goal, the agency must provide no less than two face-to-face contacts per month with the family, beginning within two weeks of admission. Visitation between the child and family, siblings, and others identified in the child's Permanency Plan must be flexible and coordinated as outlined by the CFTM. Family involvement guidelines include any individual(s) identified in the Permanency Plan or as a result of a CFTM who are identified as a permanency or discharge option for the child.

F. Placement Types

1. The Private Provider, in coordination with the Department of Children's Services staff, all involved adults, and age-appropriate child/youth identifies services needed by the child and family to progress to permanent placement out of State custody. Placement is determined through the use of this Child and Family Team Meeting, which addresses the treatment needs of the child and family, child safety issues or concerns, and community safety.
2. The Provider must provide, or have an approved subcontract for the following array of placements:
   a. **Level II Group Care** is a group care facility which meets the Level II Scope of Services in the Provider Policy Manual. There is a presumption that children in Level II will attend public school. Educational services must be met through the most appropriate environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs. **If a group care site operates an on-site school, the school must be approved by the State Department of Education and recognized by the Department of Children's Services.** Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a Child and Family Team review, as outlined in Department of Children's Services educational policy.

b. **Interdependent Living** is a group home with eight (8) or fewer children in one location, which meets the scope of services for Level I. This level of service includes specialized independent living programs. Placement in any Level 1 group care program with over eight (8) children in one location must be approved by the regional administrator and specifically recommended as the most appropriate placement site through a Child and Family Team Meeting. Children/youth in Interdependent Living Programs will attend public school. Educational services must be met through the least restrictive environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs.

c. **Continuum Foster Care** is high intensity foster care which includes recruitment, training, and support services to resource parents trained to meet the needs of youth who are appropriate for family based care but require a higher level of behavioral intervention, case coordination, therapeutic support services and/or counseling/therapy services Children and resource families at this level of care require a high level of intervention, wraparound, and coordinated services to facilitate stability. There is a presumption that children in Level II will attend public school. Educational services must be met through the least restrictive environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs.

d. **Foster Care** Each continuum has a separate foster care contract. When a Child and Family Team determines that the child and family do not require wraparound services, intensive behavioral intervention, and intensive case management, the team may recommend movement or transition from the continuum contract to a foster care contract. Children in Level II foster care will attend public school. Educational services must be met through the least restrictive environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs.

e. **In-home Services** refers to a wide array of services offered to families and children placed with their permanency family. These services are coordinated and include, but are not limited to, services identified in the Permanency Plan as necessary to achieve permanency and stability for the child and family. Services must meet standards outlined in SECTION SEVEN, IN HOME SERVICES, of the Provider Policy Manual.

III. LEVEL III CONTINUUM OF CARE

A. Admissions/Clinical Criteria

The Level III Continuum of Care programs will meet all requirements stated in the Continuum of Care Core Requirements section of the Provider Policy Manual. The following criteria will also apply to all Level III Continuums.

1. Children have mental and behavioral health issues that require 24-hour intervention and supervision.
2. Children have been identified as having moderate mental health treatment needs.
3. There is evidence of an impairment of functioning in the following settings: family, school, and community. Children in this population may have significant disturbances in environmental relationships such as severe disruptions of relationships within the family or with significant others as well as persistent maladjustment of peer and other social relationships or other influencing systems, which interfere with learning and social development.
4. Children may have a serious disturbance of affect behavior or thinking or the potential for danger to self or others. There may be evidence of serious developmental disturbances such as a failure to achieve or behavioral patterns with destructive psychological physical or social consequences.
5. The need for a therapeutic, positively-based milieu to provide education, socialization and/or counseling/mentoring.
6. Children may be of any adjudication type.
7. Children appropriate for this level of care may have medical or psychiatric disorders which require twenty-four (24) hour intervention and supervision such as an eating disorder, disordered thought process, brittle unstable diabetes, suicidal ideations, sexual impulse disorders or impulsive acts of aggression.
8. Children in need of this level of care may have substance abuse treatment needs but are not in need of medical detoxification.
9. Children in this service type may need evaluation and assessment for psychotropic medication and medication management.
10. Children may pose high risk for elopement, instability in behavior and mental health status, or occasionally experience acute episodes.
11. Children with primary diagnosis of mental retardation are evaluated on a case-by-case basis. Children with an IQ lower than 55 or who have adaptive functioning indicating moderate to severe mental retardation are not appropriate unless the agency is licensed for this service type.
12. Children appropriate for this level of care shall not be in need of acute psychiatric hospitalization and/or require incarceration for major acts of violence or aggression within the past six (6) months.
13. The private provider agency may not reject children deemed appropriate for the scope of service.
14. Families of these children often have serious needs for intervention, therapeutic support, and coordination of services and may have multiple needs including need for counseling/therapy, alcohol and drug intervention, community support, mental health service coordination, domestic violence intervention, or other issues.

B. Personnel

1. The service has qualified personnel who can meet the developmental and therapeutic needs of all children accepted for care and services.
2. The agency shall adhere to the personnel requirements for each placement type within the continuum, as outlined in the Core Standards, Foster Care, Continuum Foster Care, and Residential sections of this manual.
3. Adequate care and supervision are provided at all times to assure that children are safe and that their needs are met in accordance with their developmental level, age, and emotional or behavioral problems.
4. The provider agency has available the services of a licensed physician on at least an on-call basis to provide and/or supervise medical and mental health care on a 24-hour basis.
5. Depending on the needs of the children in care, the services of qualified professionals in various mental health disciplines, consultants and specialists in dentistry, medicine, nursing, education, speech, occupational and physical therapy, recreation, dietetics, and religion are available among the agency's personnel or through cooperative arrangements and are integrated with the core services of the agency to provide a comprehensive program.
    a. regular and specialized education
    b. individual counseling/therapy provided by a licensed or appropriately credentialed clinician
    c. group counseling/therapy provided by a licensed or appropriately credentialed clinician
    d. family counseling/therapy provided by a licensed or appropriately credentialed clinician
    e. activity counseling/therapy
    f. specialized treatment services such as independent living training, values clarification, alcohol and drug intervention, sexual abuse, anger management
    g. alcohol and drug treatment by an alcohol and drug counselor with appropriate license or certification
    h. psychiatric treatment by a licensed psychiatrist onsite or available through local service as needed (psychiatric assessment, psychotropic review, crisis intervention)

C. Service Overview

1. The agency shall meet the standards set forth in SECTION ONE, Core Standards, Foster Care, Continuum Foster Care, Residential and Continuum of Care Core Requirements.

   At least 50% of all children in a Level III Continuum must be in a family-based setting.
2. Level III continuums develop and provide services in a flexible, individualized manner to best meet the needs of the child and family. Service needs are determined through the utilization of Child and Family Team Meetings. Services are determined through a review of expected discharge placement as indicated in the child's Permanency Plan, referral information, history, and treatment needs of the child and family.

D. Service Components within the per diem

The following services are required within the per diem payment:

1. **Counseling/Therapy**. Requires direct services in the form of individual, group, and/or family counseling/ therapy and treatment planning For programs specifically serving sex offenders, therapy

must address sexual perpetration issues in addition to meeting other therapy needs. Persons providing counseling/therapy must be appropriately licensed, certified, credentialed, supervised and must follow State health care provider licensing guidelines.

a. **Sexual Abuse Counseling/Therapy and Sexual Perpetration Therapy**. Counseling/therapy and intervention services to address issues related to sexual abuse and sexually reactive behaviors

b. **Substance Abuse Counseling/Therapy**. Counseling/therapy and intervention services targeting issues related to alcohol and/or drug misuse

2. **Intensive Day Treatment** Involves structured group activities in residential and group care, designed to encourage, direct, and instruct children in the acquisition of skills needed to develop self-sufficiency and personal competence, and prevent or reduce the need for institutionalized care. Programs must operate or subcontract for intensive day treatment services licensed through Tennessee Department of Mental Health/Developmental Disabilities, for access by children identified as needing this level of intervention.

3. **Therapeutic support** Non-medically necessary intervention and support services in the form of individual, group, or family interaction, which address behavioral or mental health needs to improve social, educational, or psychological functioning.

   a. **Sexual Abuse and Sexual Perpetration Intervention and Therapeutic Support** Behavioral intervention and support services to address issues related to sexual abuse and/or sexually reactive behaviors in coordination with outpatient therapy recommendations and the needs of the child and/or family.

   b. **Substance Abuse Intervention and Therapeutic Support** Behavioral intervention and support services targeting issues related to alcohol and/or drug misuse in coordination with outpatient therapy recommendations and needs of the child and/or family.

4. **Referral and coordination of medically necessary outpatient counseling/therapy services** as indicated in the child's Permanency Plan and/or prescribed to meet the mental health needs of the child.

5. **Educational Services**.

   Educational services must be met through the most appropriate setting to meet the educational needs of the child. This includes both general and special education programs.

   For specific details, refer to Section I. Continuum of Care Core Requirements, H. Education.

6. **Case Management**. Case management/coordination services are provided by an individual, who at a minimum has a bachelor's degree in one of the social sciences and at least one year of social services experience. Case management includes coordination with the Child and Family Team in the development and implementation of the treatment plan and Family Service Plan, monitoring the implementation of this plan, and locating all services and placements a child and/or family may need while enrolled in the continuum. Case Management includes participating in all CFTMs, attending all foster care review meetings, and court hearings. It also includes documenting progress, barriers and resolution to these barriers, maintaining contacts with DCS, revising the treatment plan, as needed, maintaining ongoing contacts with the child and/or family, planning and implementing the progression of the child and/or family through the continuum. CFTMs will be utilized at all critical decision making points as outlined in the Engaging Families Policy.

7. **Family Services**. Services are provided to family members and persons identified in the Permanency Plan or the CFTM or who are identified as discharge options, which facilitate reunification, kinship care, permanency or adoption. Services to families include linking families to community resources and services to increase stability and meet the goals of the Permanency Plan. Services to the family begin at the admission of the child into the contract and are fully incorporated into all treatment plans. Flex funding may be requested through the DCS FSW to address the basic living needs of the family (rent, utilities, child care, etc.), or identified service needs which are not covered in the Scope of Services.
8. **Diligent Search**. This service is a search for potential family members to be a support or placement for a child and/or recruitment of family or individual to be an adoptive, resource, relative, or planned permanency living arrangement support for a child.
9. **Interdependent Living Services**. These services include therapeutic support, skill-building, service coordination, and life skills coaching/support which focus on facilitating the skills and support for the youth to live successfully and independently in the community. Age appropriate self-sufficiency skills must be incorporated into treatment plans for all children. Children ages fourteen (14) and above must have specific independent living skills training and development incorporated into service and treatment plans. Establishing connections with persons able to provide support throughout the child's life is an essential component of this service and to successful independence. Chaffee Independent Living Funding may be used to augment services as outlined in DCS Interdependent Living Policy
    a. Job Placement Assistance. Assistance provided by the Provider, contracted staff, certified guidance counselor, school system, or other approved entity, in helping a child find appropriate part or full time employment
    b. Vocational Assessments/Services/Planning/Training. Administering and implementing vocational aptitude assessments, interest surveys, vocational planning and coaching, and vocational training. Services for vocational training and coaching may be accomplished through enrollment in vocational training courses or approved apprenticeships.
    c. Self-Sufficiency Skill Training. Evaluation of the level of independent living skills, with targeted training, mentoring, coaching, and teaching of skills to enable independence as part of the treatment plan and delivery
    d. Development of Planned Permanency Living Arrangement Contract. Development and signature of P.P.L.A. contract for youth, specifying relatives or adult(s) committing to ongoing support, as appropriate for the child.
    e. Transitional Living Services. Career planning, enrollment preparation for post secondary education, apartment living, or other appropriate services for children moving to independence
10. **Adoption Services**. Continuums are required to provide the full range of adoption services to all children in DCS full guardianship in the care of the Continuum whose goal is adoption. The Continuum Provider will provide full case management services for foster care and adoption, if appropriate; perform all steps necessary to prepare the child for adoption; perform all steps necessary to provide diligent search for an adoptive family and prepare the adoptive family; perform all services necessary to place the child for adoption, including compliance with legal requirements and other binding documents, ICPC, and securing adoption assistance when the child is eligible; perform post placement services through finalization of the adoption; provide post finalization

services; respond to disruptions; and complete all required reports and procedures, including sealing of the adoption record. Continuum Providers will be reimbursed at the per diem rate for the adoption services delivered up to the date of the signing of the adoption placement agreement with an adopting family. *See Section Eight - ADOPTION*

11. **Adjunct and Specialized Services**. The needs of each child and family are unique. All services must be individualized, based on the needs of the child and family and barriers identified in CFTMs. Services may be obtained by utilizing community resources, developed by the Agency, or obtained through a subcontract arrangement. Services identified by the CFT as necessary for the child and family which are not covered in the Scope of Services may be accessed or developed through a flex funding request made by the DCS FSW. Appropriately licensed certified and supervised professionals must provide out patient, medically necessary counseling/therapy and medical services. Adjunct and Specialized Services include:
    a. Parenting Skills Training. Individualized coaching and training to assist parents with issues related to discipline, child development, child-rearing skills, and behavioral intervention. Services must meet the needs of the family as identified in the Permanency Plan and be available at times and locations which best meet the family's needs.
    b. Dietetic and Nutrition Services. Services which are necessary to address issues related to diabetes control, obesity, malnutrition, and/or eating disorders.
    c. Coordination of Medical and Nursing Services. Coordination and documentation of all Early Periodic Screening Diagnosis and Treatment (EPSDT) services provided by a licensed health care provider of the type and duration indicated by documented medical need.
    d. Crisis Intervention/Stabilization. Services provided on a twenty-four (24) hour basis to a child and/or family experiencing a medical, mental health, parent/child interaction, or other significant emergency need. Services must, at a minimum, be provided by an individual with a Bachelor's Degree in one of the social sciences with one-year experience and who has supervisory access to a licensed professional possessing, at a minimum, a Master's Degree in one of the behavioral sciences.
    e. Emergency Placement Services. Services are available 24 hours a day through an on-call system which stabilize children and families by locating alternative short-term placement in emergency situations.
    f. Respite. Services to provide agency resource parents or family members appropriate periods of break in care giving. Respite is defined as a brief break in care, with the child returning to the original placement. Respite is generally seventy-two (72) hours or less in duration.
    g. Community Support Services. Identification, recruitment, development, and referral to community services to support the service needs of the child and/or family to maintain and facilitate permanency is an essential component of services to children and families.
    h. Services for Developmentally Delayed Children. Specialized services designed to address the developmental deficits and developmental skills needed and assistance with transitioning youth to adult services in coordination with the Department of Mental Health and Developmental Disabilities.

i. Family Planning Counseling and Referral. Education and guidance provided to a youth and/or family regarding planning/preventing pregnancy. These services may include alternatives available for pregnant teens.

j. Placement Stability and Intervention - Wraparound, emergency response, crisis intervention, or child/family specific intervention and support which stabilize placement and avoid movement or disruption. Services are available 24 hours on an on-call basis.

E. Services to the Permanency Family

The Agency will follow all criteria listed in Core Standards including 2 face-to-face contacts per month and other services recommended by the Child and Family Team Meeting.

F. Placement Types

The Provider, in coordination with the Department of Children's Services staff, all involved adults, and age appropriate child/youth identifies services needed by the child and family to progress to permanent placement out of State custody. Placement is determined through the use of a CFTM which addresses the treatment needs of the child and family, child safety issues or concerns, and community safety. The Provider must provide, or have an approved subcontract for the following array of placements:

1. **Residential Treatment**. A residential treatment facility meeting Level III standards and licensed as a mental health residential treatment facility for Children and Adolescents through the Tennessee Department of Mental Health and Developmental Disabilities. The child requires 7 days per week/24 hours per day to develop skills necessary for daily living and to develop the adaptive and functional behavior that will allow him/her to live in a less restrictive setting. This setting offers a total milieu of therapy, active psychotherapeutic intervention, and specialized care in a restrictive and/or specialized setting. These services may include specialized intervention such as substance abuse or sexual offender intervention services. Placement in Residential Treatment must be clinically necessary and documented as the most appropriate option for treatment. Educational services must be met through the most appropriate environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs. Level III residential treatment programs must operate or have through subcontract, on-site educational programs approved by the State Department of Education and recognized by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a child and family team review, as outlined in Department of Children's Services educational policy.
2. **Group Care.** A group care facility, which meets the Level III Scope of Services. This service type includes wilderness, alcohol and drug intervention programs, and programs with self-contained educational programs. This level of service includes specialized independent living programs. Placement of a **Brian A. class member** in any Level III Group Care Program with over eight (8) children in one location must be approved by the Regional Administrator and be specifically recommended as the most appropriate placement site through a CFTM.

   Educational services must be met through the most appropriate environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs. Level III residential treatment programs must operate or have through subcontract, on-site educational programs approved by the State Department of Education and recognized by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a CFT review, as outlined in the

Department of Children's Services educational policy.

3. **Continuum Foster Care**. High intensity foster care which includes recruitment, training, and support services to resource parents trained to meet the needs of youth who are appropriate for family based care but require a higher level of behavioral intervention, case coordination, and/or counseling/therapy services.

   Children and resource families at this level of care require a high level of intervention, wraparound, and coordinated services to facilitate stability. Children in Continuum foster care will attend public school.

   Educational services must be met through the most appropriate environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs. If a Level III continuum foster care student exhibits extreme negative behavior in school, the program must provide whatever therapeutic supports are necessary to maintain the child in public school. If students ultimately cannot attend public school, the agency program must provide an optional school that is approved by the State Department of Education and recognized by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a child and family team review, as outlined in Department of Children's Services educational policy.

4. **Foster Care**. Each continuum has a separate foster care contract. When a CFT determines that the child and family do not require wraparound services, intensive behavioral intervention, and intensive case management, the team may recommend movement or transition from the continuum contract to a foster care contract.

5. **In-Home Services**. Each continuum has a wide array of services offered to families and children placed with their permanency family. These services are coordinated and include but are not limited to services identified in the Permanency Plan as necessary to achieve permanency and stability for the child and family. Services must meet standards outlined in the Provider Policy Manual, SECTION SEVEN, IN HOME SERVICES.

G. Accessing Managed Care Organization (MCO) and Behavioral Health Organization (BHO) Services

1. With some limited exceptions, children in DCS care are eligible for TennCare. While in custody, and for six months after leaving custody if remaining TennCare eligible, the Managed Care Company assignment will be TennCare Select, the MCC serving custody children. The MCC provides all medically necessary TennCare Covered Services. Because Continuum providers are responsible for behavioral therapeutic services that are also funded in part by TennCare through DCS interagency agreement, coordination of outpatient mental health services is required.
2. Determinations of when a Level III continuum provider is responsible for providing a mental health service as well as when the provider may access that service through an outside BHO provider and have it paid for directly by TennCare depends on the type of setting in which the child is placed.
   a. When a child in a Level III Continuum is being served in a residential treatment facility, the continuum provider is responsible for supplying all psychiatric services (e.g., psychiatric evaluations, medication management) and all needed specialized treatment services (e.g., alcohol and drug treatment, sexual offender treatment).

b. When a child in a Level III continuum Is being served in a community placement (i.e., group home, resource home), the continuum provider may access an outside BHO provider in the community to supply psychiatric services and specialized treatment services. The outside BHO provider who delivers these services would be paid via TennCare. The continuum provider does not pay for these services out of their per diem.

3. For all children in Level III continuum programs, psychological testing can be obtained from an outside BHO provider. Continuum providers are not responsible for providing psychological testing as part of their daily per diem rate and scope of services.

IV. LEVEL III CONTINUUM SPECIAL NEEDS PROGRAM REQUIREMENTS

A. General Characteristics:

The Level III Continuum Special Needs (L3CSN) of Care is designed to serve a unique population of children/youth who cannot be served in other continuum programs due to their unique needs.

The categories of L3CSN services that will be available under this scope of services are: Alcohol & Drug (A&D), Sex Offender (SO) and mental health/behavioral (MHB) treatment. Agencies may provide any or the entire specialty service range (A&D, SO, MHB). Providers delivering MHB services must do so statewide.

B. Admission/Clinical Criteria

1. Child/youth will have more difficult and challenging needs/behaviors and will most likely have an immediate need for initial short-term or intermittent stays in a Residential Treatment Facility (RTF):
    a. Child/youth has/had serious symptoms or impairments that prevent regular utilization of outpatient treatment and, therefore, the structure of residential or acute care may be needed from time-to-time;
    b. Child/youth has/had serious symptoms OR major impairment in several areas, such as work or school, family relations, judgment, thinking, mood or certain medical conditions.
    c. Child/youth has/had a moderate to high risk for elopement, instability in behavior and mental health status or has occasionally experienced acute psychiatric episodes;
    d. Child/youth may have **multiple** conduct problems that indicate a high risk to the community and or conduct problems that cause considerable harm to others as indicated in the DSM-IV-TR, Conduct Disorder Diagnostic Criteria;
    e. Child/youth may have several juvenile justice adjudications that do not rise to the level of incarceration; and,
    f. These symptoms are not due exclusively to mental retardation, organic dysfunction or developmental disabilities.
    g. The difficulties are amenable to “active psychiatric treatment.”
2. In addition, child/youth may have the following moderate to severe conditions:
    a. Dually diagnosed,
    b. Pervasive developmental disorders,
    c. Sexual aggression/sexual behavior problems,
    d. Substance use related disorder but are not in need of medical detoxification;
3. Level 4 child/youth that is stabilized and appropriate for this level of care;
4. Level 3 Continuum children are also eligible for these services;
5. Child/youth has not successfully responded to less intensive interventions or has been denied admission or discharged from less intensive placements because of their emotional or behavioral problems;

6. A diagnosis of mental retardation **may not** be used as a basis to refuse admission to a child/youth when the child/youth's behavioral issues fall within the program's Scope of Service. Review of referrals of child/youth with a diagnosis of mental retardation must be based on assessment of both the child/youth's intellectual and adaptive level of functioning using professionally accepted assessment instruments;
7. Child/youth who is considered *ineligible* for these services include child/youth in need of Level 4 services or acute care, youth determined to need placement in a Youth Development Center (YDC) or child/youth in need of a lower level of care; and
8. Provider is required to accept all referrals for child/youth deemed to meet the need for this level of service unless the provider is at full capacity or if the provider has justified clinical documentation that indicates either a higher level of care or a Youth Development Center (YDC) placement is more appropriate. Such a scenario will require either the region or the provider to file an appeal under the CFTM appeals process.

C. Assessment

1. The **Child and Adolescent Needs & Strengths (CANS)** instrument shall be used as a screening tool for children and youth whose needs do not meet the intensity of a Level 3 Continuum Special Needs Residential Treatment Facility. Prior to the CFTM, the psychologist should be consulted and CANS (if available) thoroughly reviewed so the team will have the recommendation available for consideration in placement related decisions.

   In order for a child or youth to be placed in a Level 3 Continuum Special Needs Residential Treatment Facility, a psychologist must determine "medical necessity". This means that whenever the psychologist, based on a review of assessments and the child's history, recommends this level of care, the CFT is expected to support this decision. Whenever a CFT cannot come to a consensus on a recommendation of medical necessity, the situation must be reviewed by Central Office clinical staff. This is intended to ensure that those children or youth who require this level of service are given every opportunity to receive it. Less intensive Level 3 services have more flexibility for the team's input, but those children or youth who demonstrate medical necessity for an RFT setting must have that level of service provided.

   - Items that might need to be considered for potential placement in this setting are CANS actionable items scoring 2 or 3 on risk behaviors and behavioral/emotional needs.

2. Youth Level of Service (YLS) - Juvenile Justice Youth at this level of service may have low medium or high YLS risk levels. Youth with very high YLS risk level scores may be appropriate for admission at this level of care based on unique case circumstances following classification at a Youth Development Center or assessment in a Level 4 treatment facility.
3. The agency shall, on an ongoing basis, reassess the needs and strengths of child/youth, regardless of setting, to determine ongoing treatment needs of the child/youth and adjust treatment accordingly.

D. Personnel

The agency shall adhere to the personnel requirements for each placement type as outlined in the Core Standards - Continuum Foster Care, Medically Fragile and Residential sections of this manual in addition to the following:

1. The service has qualified clinical personnel trained to work within the specific treatment service category.
2. The program clinical director must be knowledgeable of current approaches to treatment within that specific service category (SO, A&D, MHB).
3. There should be clear guidelines and procedures on how clinical staff is supervised and how clinical staff is trained.

E. Individualized Treatment Plan

1. Agencies will follow their licensing and/or accreditation standards for developing a treatment plan (individualized plan of care) within the required number of days. A more formalized treatment plan must be developed after testing and/or assessment has occurred. The treatment planning process must include the family and youth as per the CFTM model for collaborative planning. This must be completed within 30 days.
2. The child's treatment plan will include a specific strengths-based family integration/reintegration treatment plan. It will also include guidelines for family participation while the child is at the facility. These family participant guidelines will contain frequency of family visits, details of visit supervision and location of visits. The agency will work with the facility to address transportation and communication barriers. Family counseling/therapy, therapeutic support and family visits shall not be contingent on the child's behavior.
3. The treatment plan also will include all goals for educational issues, mental health needs (including therapy and psychiatric medications), substance use issues, physical/medical concerns and family participation in treatment.
4. The individual treatment plan should consider discharge goals and estimated length of stay. Discharge planning should begin at admission and be an ongoing process.
5. The treatment plan will be updated at least quarterly.

F. Service Overview

1. The agency will provide a continuum of services;
2. The program will have a clear theoretical approach that outlines a philosophy and methods of treatment that are based on best practices with a trauma-based focus approach;
3. Program will provide an evidence-based treatment model specific to the child/youth's needs;
4. The program must demonstrate that it has the capacity to address the clinical/behavioral and general delinquent dynamic risk factors in addition to other health, mental health and educational needs;
5. The provider will utilize the Youth Level of Service Needs Checklist (DCS Form CS-0919) to target interventions to reduce criminal recidivism; and,
6. The provider will use the CANS to target/identify child/youth's specific strengths and needs as well as charting child/youth's progress toward timely permanency or less restrictive setting placement.

G. Service components within the per diem

1. Residential Treatment:
   a. Sex Offender Treatment (refer to Enhanced Level 3 Sex Offender [General/MR] scope of services);

b. Alcohol & Drug Treatment (refer to Enhanced Level 3 A&D scope of services)

c. Mental Health/Behavioral Treatment (refer to Standard Level 3 RTF scope of services)

2. Group Home Care;

3. Continuum Foster Care scope of services;

4. Medically Fragile scope of services;

5. Standard Foster Care scope of services;

6. In-Home scope of services; and,

7. Adoption services (must have specialized adoption staff identified for delivering this service component).

H. Education of the child/youth:

See Level III Continuum (RTF placement must have an approved in-home school).

I. Monitoring Progress

The agency will monitor progress and will submit monthly summaries to DCS Service Appeals Tracking (SAT) Coordinators.

J. Services to the Permanency Family

See Level III Continuum.

Families of these children/youth often have serious needs for intervention, support and coordination of services and may have multiple needs including need for counseling/therapy, alcohol and drug intervention, community support, mental health service coordination, domestic violence intervention or other issues.

K. Utilization Review

1. The agency will meet the Core Standards.

2. Agency will participate in DCS Utilization Review (UR). UR usually occurs at 30 day intervals.

L. Discharge Criteria

Children/youth will be discharged according to the decision of the CFTM and using established CFTM protocol.